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Highway Hijinks

US ARMY COMBAT READINESSS CENTER

The engineer platoon was almost mission complete after a successful deployment that included mechanical destruction of a three-story building. The platoon's last mission included discharging the barge transporting their equipment and conducting a convoy back to home station. Unfortunately, a series of human errors led to an Army Motor Vehicle accident that tarnished an otherwise successful deployment.

The accident sequence

The platoon began discharging equipment from the barge the day of the accident. Shortly thereafter, the platoon leader had drivers start convoying vehicles loaded with equipment from the port back to home station. The platoon leader's initial intent was to have two serials moved in the morning and two in the afternoon; however, he never stated his intentions to the platoon.

Instead, five serials departed in the morning, with some consisting of a single vehicle. Four of those five serials required convoy clearances, special hauling permits and escort vehicles with rotating amber warning lights, none of which were available or used. One of the drivers wasn't trained on the truck he was operating, nor did he have a military driver license.

The fifth serial—the accident vehicle—was an M916A3 truck that was pulling an M870A1 trailer loaded with a Link-Belt 330LX hydraulic excavator. This serial required but did not have a convoy clearance, special hauling permit or the escort vehicles with rotating amber warning lights. The HYEX also wasn't on the unit's modified table of organization and equipment; it had been leased from a civilian vendor as a special requirement for the mission.

None of the unit's Soldiers were trained or licensed to operate the HYEX, but two of them had previous experience with the excavator in civilian jobs. Unfortunately, the platoon leader didn't have those two Soldiers on the mission that day. The Soldiers that were on duty improperly loaded the HYEX on the trailer, leaving it more than 4 feet above the maximum safe height for the selected route. The platoon leader and driver failed to measure the vehicle's load height, although the driver did say he thought it was too high.

It's not hard to imagine what happened next. As the truck and trailer traveled on a five-lane highway, the HYEX struck a pedestrian walkway overpass. No one was hurt, but the impact damaged the HYEX, the trailer and two civilian vehicles, and traffic on the busy highway was backed up for about 14 hours. The overpass suffered such heavy damage the state demolished it.

Why the accident happened

The platoon leader briefed the company commander on the movement mission three weeks before the execution date. The company commander then gave the details to the platoon leader, who'd been in charge of the deployment mission since its beginning. This is where the series of errors began.

The company commander told the battalion staff when the equipment was to arrive. The battalion staff considered the mission routine and provided no oversight. No operations order was published, and no one at the battalion level was backbriefed to ensure the company could perform the mission. More importantly, the company had no trained unit

movement officer. Although the battalion leadership was aware of the requirement to have movement documents, they failed to assist or ensure the unit had the required convoy clearances or special hauling permits for tracked, overheight and overwidth vehicles.

The same errors occurred at the company level. An operations order wasn't published, and the unit failed to conduct backbriefs and rehearsals to ensure the platoon could perform the mission. The company commander also didn't know the platoon leader's concept of operations for the mission. The company commander was the approval authority for low-risk missions and was aware of the movement documents requirement, but he didn't ensure there was an approved risk assessment matrix for the mission or that the platoon leader had the necessary documents.

The errors continued through to the platoon level. The platoon leader briefed his platoon members a week before the mission, but the brief wasn't clear. Platoon members weren't assigned to mission-specific positions such as discharge team members, convoy/serial commanders, drivers or truck commanders. The platoon leader also didn't have an approved risk assessment matrix for the mission. The platoon dispatched the four M916A3 trucks used during the mission from a sister unit's motor pool but failed to document the and preventive maintenance checks and services on the trucks and trailers.

What can be done?

This accident involved leader and individual error through the battalion, company and platoon levels. Leaders understood the standards but failed to ensure their subordinates followed them. There are several ways this accident could've been prevented, including:

- Operating vehicles in accordance with federal, state, local and military regulations, including having the appropriate convoy clearances, special hauling permits and escort vehicles.
- Only allowing trained and licensed Soldiers to operate equipment.
- Developing special training requirements to train and license operators on nonstandard and non-MTOE equipment.
- Properly planning, coordinating, briefing, backbriefing and rehearsing missions, assuming none are "routine."
- Paying special attention to oversized loads and validating their size before movement. Failing to do so could spoil an otherwise successful deployment.